OMB No. XXXX-XXXX
Expiration Date: XXXX-XXXX

**Cross-site Evaluation of the Garrett Lee Smith Memorial (GLS) State/Tribal Youth Suicide Prevention and Early Intervention Program**

# Early Identification, Referral and Follow-up (EIRF) Individual Form

**Date: (Date of identification):** | | | | | | | | | | |

Month Day Year

**Participant ID (Site-assigned):**

**Sources of information used to complete this form. (Select all that apply.)**

- ❑ Case record review or existing data system
- ❑ Directly from a provider (i.e., case manager, clinician, mental health professional)
- ❑ Directly from a gatekeeper (i.e., not a mental health professional)
- ❑ Other **(Please describe – e.g. "self": _____)**

**Early Identification Activity Setting (Select one.)**

- ❑ High school
- ❑ College or University
- ❑ Child Welfare Agency
- ❑ Juvenile Justice Agency
- ❑ Law Enforcement Agency
- ❑ Community-based organization, recreation or after school activity
- ❑ Physical Health Agency (e.g., primary care, pediatrician's office, etc.)
- ❑ Mental Health Agency
- ❑ Home
- ❑ Emergency Response Unit or Emergency Room
- ❑ Digital medium (e.g. Facebook or text message)
- ❑ Other **(Please describe: _____)**

**Zipcode where the youth was identified**

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**Source of Early Identification of Youth [Select one]**

- ❑ Screening (Select this option for all youth identified at-risk through a group screening activity corresponding to an EIRF Screening Form no matter who conducted the screening. This response option should be selected for each youth determined to be at risk at the conclusion of the entire screening process—for example, following the post-screening interview or debriefing process.)
- ❑ Family member/ Foster family member / Caregiver
- ❑ Mental health service provider (e.g., clinician, school counselor, etc.)
- ❑ Teacher or other school staff except school counselor (including college or university staff)
- ❑ Community based organization, recreation, religious, or after school program staff
- ❑ Child welfare staff
- ❑ Probation officer or other juvenile justice staff
- ❑ Primary care provider (i.e., pediatrician)
- ❑ Emergency responder or emergency room staff
- ❑ Police officer, security guard, or other law enforcement staff
- ❑ Peer
- ❑ Other **(Please describe – e.g., "self":_____)**

**Section I. Early Identification**

1. **Youth Age: (years)**
2. **Youth Gender:**
   - ❑ Boy
   - ❑ Girl
   - ❑ Transgender
   - ❑ Other **(Please specify) _____**

3. **Is the youth of Hispanic or Latino cultural/ethnic background?**
   - ❑ Yes
   - ❑ No [Skip to item 4]
   - ❑ Don't know [Skip to item 4]

**3a. [IF YES] Which group describes his/her Hispanic or Latino cultural/ethnic background? Is he/she (Select all that apply)?**

- ❑ Mexican, Mexican-American, or Chicano
- ❑ Puerto Rican
- ❑ Cuban
- ❑ Dominican
- ❑ Central American
- ❑ South American
- ❑ Hispanic origin in local MIS but not represented in list above **(Please specify: _____)**

4. **Which group(s) describes the youth? Is he/she (select all that apply)?**
   - ❑ American Indian or Alaska Native
   - ❑ Asian
   - ❑ Black or African American
   - ❑ Native Hawaiian or Other Pacific Islander
   - ❑ White
   - ❑ No race available **(Please describe: _____)**

**Section II. Referral Information**

By mental health

5. **Was the youth referred for either mental health or nonmental health related services?**

   ❑ Yes, the youth was referred to mental health and nonmental health related services [Skip to item 6, then continue to 7].

   ❑ Yes, the youth was referred to nonmental health related services only [Skip to item 6].

   ❑ Yes, the youth was referred to mental health related services only [Skip to item 6].

   ❑ No

5a. **[IF NO] Why was the youth not referred for any type of services? (Select the ONE primary reason).**
   - ❑ Youth was already receiving services or supports.
   - ❑ No capacity at provider agencies to receive a referral.
   - ❑ Youth determined not to be at risk during referral process (for example, if a youth is identified by his or her teacher at school but upon discussion with the school's care coordinator, they determine that the youth is not at risk for suicide and does not need a referral for further mental health services).
   - ❑ Unable to contact youth
   - ❑ Other **(Please describe: _____)**

**If the youth was not referred to any type of services (i.e. you answered item 5a), please end the survey. Otherwise, please continue.**

**6. [IF YES] Where was the youth recommended for nonmental health support? (Select all that apply.)**
   - ❑ School or other academic organization
   - ❑ Family or extended family
   - ❑ Community based organization, recreation, religious, or afterschool program
   - ❑ Physical health provider (e.g., medical, vision, hearing, dental)
   - ❑ Law enforcement or juvenile justice agency
   - ❑ Child welfare agency or shelter
   - ❑ Other **(Please describe: _____)**

If youth WAS referred to mental health related services, continue to question 7.

If youth WAS NOT referred to mental health related services END SURVEY NOW.

**7. Date of referral for mental health related services:**

Month Year

**7a. Where was the youth referred for mental health related services? (Select all that apply.)**

- ❑ Public Mental Health Agency or Provider
- ❑ Private Mental Health Agency or provider
- ❑ Psychiatric Hospital/Unit
- ❑ Emergency Room
- ❑ Substance Abuse Treatment Center
- ❑ School Counselor
- ❑ Mobile Crisis Unit
- ❑ Crisis hotline
- ❑ Other **(Please describe: _____)**

**Section III. Follow-up to Mental Health Referral**

**8. In the 3 months following the date of referral, did the youth receive mental health services as a result of the mental health referral?**

- ❑ Yes [Skip to item 9]
- ❑ No
- ❑ Don't know

**8a. [IF NO] What was the primary reason why the youth did not receive a mental health service?**

- ❑ Made an appointment for youth but youth did not attend.
- ❑ Youth was wait-listed for at least 3 months.
- ❑ Parent or youth refused service for personal reasons (i.e., not financial reasons).
- ❑ Youth did not have insurance or could not afford services.
- ❑ Youth did not have transport to the appointment.
- ❑ Other (**Please describe**:_____)

**8b. [IF Unknown] What was the primary reason why you do not know if the youth received a mental health service?**

- ❑ Parent permission for tracking required but not granted.
- ❑ No tracking system in place.
- ❑ Tracking system requires an agreement to share data but the agreement is not in place.
- ❑ Tracking system prohibits data sharing.
- ❑ Parent or youth could not be contacted.
- ❑ Other (**Please describe**:_____)

**If youth did not receive mental health services or if that is unknown [i.e., you answered question 8a or 8b]: End survey. Otherwise, please continue.**

**9. [IF YES] What service did the youth receive at the initial appointment? (Select all that apply.)**

- ❑ Mental health assessment
- ❑ Substance use assessment
- ❑ Mental health counseling
- ❑ Substance abuse counseling
- ❑ Inpatient or residential psychological services
- ❑ Medication
- ❑ Other service **(Please describe: _____)**

**10. [IF YES] Date of initial appointment:**

Month Day Year

**11. Zip code of initial appointment location**

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**12. Did the youth attend a second visit for a mental health service within 1 month after the first appointment?**

- ❑ Yes [Skip to item 9]
- ❑ No
- ❑ Don't know

**12a. [IF NO] What was the primary reason why the youth did not receive a second mental health service? (Select all that apply.)**

- ❑ Made an appointment for youth but youth did not attend.
- ❑ Youth was wait-listed for at least 3 months.
- ❑ Parent or youth refused service for personal reasons (i.e., not financial reasons).
- ❑ Youth did not have insurance or could not afford services.
- ❑ Youth did not have transport to the appointment.

- ❑ Other (**Please describe**:_____)

**12b. [IF unknown] What was the primary reason why you do not know if the youth received a second mental health service?**

- ❑ Parent permission for tracking required but not granted.
- ❑ No tracking system in place.
- ❑ Tracking system requires an agreement to share data but the agreement is not in place.
- ❑ Tracking system prohibits data sharing.
- ❑ Parent or youth could not be contacted.
- ❑ Other (**Please describe**:_____)

**If youth did not receive mental health services or if that is unknown [i.e., you answered question 12a or 12b], end survey. Otherwise, please continue.**

**13. [IF YES] What service did the youth receive at the second appointment? (Select all that apply).**

- ❑ Mental health assessment
- ❑ Substance use assessment
- ❑ Mental health counseling
- ❑ Substance abuse counseling
- ❑ Inpatient or residential psychological services
- ❑ Medication
- ❑ Other service **(Please describe: _____)**

**14. [IF YES] Date of second appointment:**

Month Day Year

**15. Zip code of second appointment location**

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